Vermont EMS Today

February 2003

From the Director

Smallpox Preparedness and Response

The United States is preparing for the possibility that we may again face an outbreak of smallpox. No one in the world has had a case of natural smallpox since 1977. The last case of smallpox in the U.S. was in 1949; Vermont's last case was in 1937. Smallpox was declared eradicated in 1980 following a successful worldwide vaccination program. Although the possibility of an intentional release of smallpox virus is considered low, the consequences would be so serious that we must be ready to quickly and effectively respond. A single case of smallpox anywhere in the world would now be considered an act of terrorism, and a national and international emergency.

Smallpox is a serious, contagious, sometimes fatal disease caused by the variola virus. In the past, smallpox has killed 30 percent of unvaccinated people who developed symptoms. In the U.S., routine vaccination among the general public was discontinued in 1972, when the risk of serious side effects (including death) from the vaccine was greater than the actual threat of smallpox disease.

There is no specific treatment for smallpox disease, and the only prevention is vaccination. The name *smallpox* is derived from the Latin word for "spotted" and refers to the raised bumps that appear on the face and body of an infected person.

There is no specific treatment for smallpox disease, and the only prevention is vaccination.

Transmission: Generally, direct and fairly prolonged face-to-face contact is required to spread smallpox from one person to another. Smallpox also can be spread through direct contact with infected bodily fluids or contaminated objects such as bedding or clothing. Rarely, smallpox has been spread by virus carried in the air in enclosed settings such as buildings, buses, and trains. Humans are the only natural hosts of variola. Smallpox is not known to be transmitted by insects or animals.

A person with smallpox is sometimes contagious with the onset of fever (prodrome phase), but the person becomes most contagious with the onset of rash. At this stage the infected person is usually very sick and not able to move around in the community. The infected person is contagious until the last smallpox scab falls off. Smallpox may be contagious during the prodrome phase, but is most infectious during the first 7 to 10 days following rash onset.

Vermont's Smallpox Preparedness and Response Plan (including acute care management): If smallpox is found in VT, the initial plan is to manage patients at the hospital in the community where the case is identified. If

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Inside

HIPAA: It's Not a Female Hippo, But It Carries as Much Weight

When the federal government enacted the Health Insurance Portability and Accountability Act of 1996 (HIPAA), its implications for health care and EMS were only suspected. We know more about HIPAA now than we did then, but there are still unanswered questions. This article addresses some of the questions EMS providers may have about the law as it is currently understood and describes sources of additional information.

What did Congress intend when it passed HIPAA legislation?

Title I of HIPAA protects health insurance coverage for workers and their families when they change or lose their jobs. Title II contains the requirements pertaining to EMS and other health care providers. The primary purpose of Title II (the Administrative Simplification section) was to save health care dollars by requiring payers, health plans and health care providers to use the same dataset for financial transactions. Until recently, there were hundreds of different datasets in use, leading to the frequent need for a full-time employee to deal solely with billing matters in a small medical office. This administrative simplification will lead to the use of one national standard dataset for electronic transfer of administrative and financial health care data. This is projected to cost several hundred million dollars over the next few years, but it is expected to save many more millions during that same period.

Why is there such widespread concern among health care providers about violating HIPAA?

Because streamlining the transfer of electronic data about patients can easily lead to the loss of privacy of health care information, the law has specific requirements about protecting the privacy of patient information. A health care provider can disclose individually identifiable health information only for purposes of health care treatment, payment or operations and only to the extent necessary. In particular, a provider must have a business associate agreement with any person or group to whom it provides health data. Passing on information to hospital staff so they can care for a patient is an example of an exception to this rule. Violating a patient's privacy rights under HIPAA can lead to specific federal penalties.

The privacy requirements of the law have been controversial in the health care community and have already been revised. Certain very restrictive requirements have been relaxed or clarified.

How is EMS affected by HIPAA?

HIPAA applies to any "covered entity," i.e., any agency that bills electronically or ever has billed electronically. This probably includes most transporting EMS agencies. First response agencies do not usually bill since government and commercial payers do not pay for treatment done solely at the scene. Like other covered entities, EMS agencies are subject to the law's requirements for both transmission of administrative and financial health care data and protection of patient privacy.

What are the compliance dates associated with HIPAA?

The transaction requirement (use of a standard dataset) went into effect on October 16, 2002 unless an agency requested an extension in writing before that date. An extension pushes the compliance date for this part of the law back to October 16, 2003.

The privacy rule goes into effect April 14, 2003. The law has no provision for an extension of this deadline.

Until recently, there were hundreds of different datasets in use,...

What do EMS agencies need to do to comply with HIPAA?

The law is lengthy and complex, but there are a number of things an EMS agency can do:

- ✓ Appoint a privacy officer. The privacy officer should become familiar with the law and its requirements and guide the agency's actions in complying with it.
- ✓ Establish a timetable for compliance. There are deadlines associated with the law and probable costs which will need to be included in your annual budget. In the long run, savings should outweigh the costs.
- ✓ Conduct a "gap analysis," i.e., determine where the gaps are between the agency's present operations and the requirements of the law.
- ✓ Identify the agency's business associates. The service will need business associates to sign such

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agreements describing how they will preserve patient privacy. This may include the service's medical director, unless the medical director is an employee of the service. Ordinarily, ambulance services are not business associates of hospitals and should not sign such business associate agreements.

- ✓ Identify the service's existing privacy-related policies and procedures, bring them together into one place, review them, then compile them with the agency's new privacy-related policies and procedures. For example, security of patient information will require a policy describing the following: proper handling and storage of patient records, reasonable precautions to take when using a fax machine for transmission of private information, the avoidance of email for transmission of private information, the use of passwords on computers and networks and the use of encryption on public networks.
- ✓ Conduct and document training for all employees by April 14, 2003. The law expects all employees to be familiar with the agency's methods of preserving patient privacy.
- ✓ Monitor the agency's policies and procedures and revise them as needed.

Where is more information available?

The best source of information is the federal government's Centers for Medicare & Medicaid Services web site (www.cms.hhs.gov/hipaa) where a great deal of information is available. The pertinent part of the law is Title II, the section on administrative simplification.

There is also a growing volume of commercially available assistance to support EMS organizations in HIPAA compliance. An internet search engine, using the term "HIPAA compliance EMS," should lead to such resources.

HIPAA holds the promise of decreasing administrative health care costs and improving privacy of medical records. Achieving this will require some effort on the part of EMS agencies, but should pay off in decreased costs and improved protection of private information.

— Mike O'Keefe
State Training Coordinator

Thinking about purchasing a new ambulance???

The United States General Services Administration (GSA) has released the newest Federal Specification for the "Star-of-Life Ambulance," KKK-1822E, which was to be fully implemented on January 1, 2003. This update, titled "Revision E," supersedes the previous "Revision D" which was adopted in 1994. All ambulances in Vermont must comply with the federal ambulance specification in force at the time the ambulance was manufactured, unless a waiver has been granted (ref: VT EMS Rules, Section 5.81 & 5.82).

The full document (a PDF document) can be viewed on-line by visiting *http://fss.gsa.gov/vehicles/buying* and clicking on "Ambulance Specification" under the heading "Publications" on the right side of the screen. The full document is quite lengthy. I also have a comparison summary available, which I am happy to email or postal mail upon request. Please contact me if you would like more information on this new revision.

— Steve Salengo
State EMS Operations Coordinator

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From the Director—

Smallpox Preparedness and Response

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the isolation capacity of community hospitals is exceeded, or patients require tertiary care due to the severity of their illness, inter-facility transfers could occur. If the number of cases in the state becomes very large, the decision to move patients to a limited number of facilities dedicated to the care of smallpox patients is possible.

Vermont's plan to implement Phase 1 of the National Smallpox Vaccination Program has been approved by the Centers for Disease Control and Prevention, and on January 22, 2003 the state took delivery of 2,000 doses of smallpox vaccine. Vermont's Phase 1 plan becomes part of the Vermont Smallpox Preparedness and Response Plan, which was submitted to Centers for Disease Control (CDC) on Dec. 1. (A summary of the plan can be found at the Health Department's website: **www.HealthyVermonters.info**). Under Vermont's Phase 1 plan, up to 2000 hospital, health care and public health workers including a limited number of EMS and public safety responders, could be vaccinated against smallpox in 2003. Only those people who have been identified by their employer, previously vaccinated against smallpox, fully informed, carefully screened and volunteering to serve will be vaccinated. The vaccine is currently NOT recommended for the general public or the first responder community at large.

EMS Role in the National Smallpox Vaccination Plan

Phase 1: In Phase 1, Vermont is attempting to create a very limited capacity to move patients between facilities in case this becomes necessary. We have defined this limited EMS capacity as:

- Four geographically dispersed ambulance services with vehicular and staffing capacity to participate in interfacility transfers.
- Vaccination of 12 EMS providers per service

The four EMS organizations selected for Phase 1 vaccinations could be asked to move patients from community hospitals to other facilities for isolation or tertiary care. The ambulance services identified for Phase 1 participation are:

- Regional Ambulance Service—Rutland
- Fletcher Allen Coordinated Transport— Burlington
- Upper Valley Ambulance—Fairlee
- Rescue Inc.—Brattleboro

These organizations were identified based on their geographic distribution, staffing, number of available vehicles, and current activities in performing inter-facility transfers.

Additional Implications:

The focus during Phase 1 is "pre-event" vaccinations. The four services involved with Phase 1 will also participate in:

- Planning and training for "best practices" in moving smallpox patients
- Assurance of necessary personal protective equipment

Smallpox Vaccine/ Vaccinating EMS Providers: For most people, smallpox vaccine has been safe and effective. But because it is made from a living virus, vaccinia, the vaccine can infect and harm some people. In the past, between 14 and 52 people per 1 million vaccinated had potentially life-threatening reactions, including severe eczema and encephalitis (swelling of the brain). Based on past experience, it is estimated that one or two people out of every 1 million vaccinated will die as a result of reaction to the vaccine.

There are a number of people for whom smallpox vaccination is contraindicated: Women who are pregnant or planning to become pregnant, people with eczema, HIV/AIDS patients and people with immune system disorders would not be candidates for vaccination in Phase 1. Participation in Phase 1 vaccinations is voluntary. No EMS provider will be required to receive the vaccine. Those who choose to receive the vaccine will need to be monitored for side effects and to assure that the vaccine "takes."

Longer term issues: The Phase 1 preparations are intended only to address a narrow segment of the EMS population to build the capacity to move a small number of smallpox patients between hospitals. If the decision is made at a national level to advance to Phase 2 (first responder, health care and public safety workers), immunizations will be made available to the broad EMS community at that time.

If EMS providers were to encounter a smallpox patient in the field, provisions are in place to rapidly administer the vaccine to persons who may have had contact with the patient. The vaccine can be administered up to three days after exposure and still provide protection.

Personal Protective Equipment: Because smallpox disease has not been seen anywhere in the world for more than 25 years, we are continuing to recommend universal precautions for routine contacts with potentially infectious blood or body fluids from all patients. EMS personnel should avoid any direct skin contact with patients who present with a rash of any sort.

As future smallpox preparedness efforts are developed, we will provide more detailed information to EMS providers regarding specific protective or cleanup measures that may become recommended by the CDC or other authorities.

Additional Information: There is a great deal of excellent information about smallpox and the preparations that are occurring in Vermont and nationally that exceed what we are able to provide in this article. You may wish to visit the following websites to learn more:

- Vermont Department of Health ***http://www.HealthyVermonters.info***
- The Centers for Disease Control ***http://www.bt.cdc.gov/agent/smallpox/***

—Dan Manz
Director, EMS

Snow Day!
Sledding Safety

During the winter, Vermont has plenty of snow and plenty of hills. Throw gravity into the mix and you've got the recipe for one of Vermont's favorite winter pastimes—sledding. Speeding down the hill can be quite a rush, but it can also be a source of injury. According to the Consumer Product Safety Commission, sledding-related injuries number 26,000 each year in the United States. Many of these injuries are minor, but the potential always exists for serious injury.

Many sledding injuries can be avoided by following these simple suggestions:

CHOOSE A SAFE SLEDDING LOCATION

The best way to make sledding safer is to choose a safe sledding location. Gently sloping hills with a large, flat "landing area" at the bottom are ideal. Avoid hills with obstructions or fixed objects like trees, signs or rocks.

Never sled near traffic. Sidewalks, driveways, parking lots and roads should be off limits for sledding.

ENCOURAGE HELMET USE

According to the Consumer Product Safety Commission, head injuries account for 15 percent of all sledding injuries. Helmet use while sledding may provide some protection from these injuries. Since sledding speeds are typically slower than bicycling speeds, bike helmets probably provide adequate protection. Helmet use is on the rise for bicyclists, skiers and skaters. Why not encourage helmets for sledding?

STAY CLEAR OF SLEDDING PATHS

Many sledding injuries happen when children are struck by sleds while walking back up the hill. Children should be encouraged to move away from the bottom of the hill as soon as possible and walk to the side of the sledding path before climbing back to the top. Children at the top of the hill should wait until the hill is clear before beginning their sled run.

Why not encourage helmets for sledding?

DON'T SLED HEAD-FIRST

Sledding feet first will greatly reduce the chances for head and neck injuries if the sled rider impacts another object.

KEEP WARM

Frostbite is a very real hazard for sled riders. Dress for the weather and know when to come in from the cold to warm up.

When sledding-related injuries do occur, EMS providers may be called to provide emergency care and transportation. There are some special considerations to take into account when responding to these types of emergencies.

Your patient might be in an area that is difficult to access with your ambulance. You may need to carry your patient over a significant distance to reach the road since driving an ambulance across a snowy field can easily get you stuck. Remember to call for additional resources if you need help. When assessing the safety of the scene, make sure that all sledding has stopped. If sleds are still flying down the hill, your scene is not safe.

As with any patient, you will need to perform a careful and complete assessment. When assessing the mechanism of injury, determine how fast your patient was traveling, identify any fixed objects the patient may have collided with and determine the position the patient was sledding in (for example head first or feet first). If your patient collided with another person, you may have two patients.

The injuries associated with sledding frequently consist of orthopedic problems. Immediately determine whether spinal immobilization is indicated and assess carefully for potential fractures during your physical exam. If a head injury did occur, carefully monitor for changes in mental status.

Remember that your patient has probably been lying in the snow long enough to become mildly hypothermic. Keep your patient warm, expose injuries only long enough to assess them and move the patient from the scene as soon as possible. En route, remove any wet clothing from your patient and minimize further heat loss by covering your patient with blankets. If your patient is showing signs of mental status change, assume that hypothermia and/or head trauma might be involved.

Enjoy the rest of your winter. Play hard, but play safe!

— William Clark
Pediatric EMS Coordinator

What's Spreading in Infection Control

How often and how well do you wash your hands while providing patient care? The answers for most health care providers are not very much and not very well. Health care workers have been the source of many documented infections that have prolonged patients' hospital stays and even resulted in death. That may change as a result of a recent report from experts in infection control. In October 2002 the Centers for Disease Control and Prevention (CDC) published "Guideline for Hand Hygiene in Health-Care Settings: Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force." The most noteworthy change in the report is the recommendation that health care workers use alcohol-based hand rubs instead of soap and water in most patient care circumstances.

Health care workers for years have learned they should wash their hands before patient contact. This teaching, however, has been honored more in the breach than the observance. It is well documented that health care workers, especially those in areas with seriously ill patients, often do not follow recommended hand hygiene practices. In response to such reports and other developments, CDC gathered representatives from major infection control organizations on a Hand Hygiene Task Force and published their report on October 25, 2002. The document contains a great deal of easily understood information on the physiology of the skin; effects of poor hand hygiene; comparative efficacy of plain soap, antibacterial soap and alcohols; hand hygiene practices; and recommendations for hand hygiene, among other topics. This article presents the task force's recommendations as they apply to EMS and lists resources for further information.

The EMS Provider's Role

The report's recommendations fall into two major categories, those for an individual provider and those for a health care agency. The major suggestion for an individual to follow is to clean the hands frequently, especially before and after certain activities and exposures. A major distinction in hand hygiene technique rests on the difference between soiled and unsoiled hands. Hands are soiled if they are visibly dirty, contaminated with proteinaceous material, or soiled with blood or other body fluids. Hands that may have been exposed to the bacterium associated with anthrax are treated as though they were in this category. If none of these conditions apply, the hands are considered unsoiled.

The preferred agent to use for cleaning unsoiled hands is an alcohol-based hand rub. A number of such products have become available in the last few years. They can take the form of a gel, foam or rinse. To use an alcohol hand rub properly, the provider should apply the amount of the product the manufacturer recommends to the palm of one hand and rub the hands together, covering all surfaces of the hands and fingers, until the hands are dry.

It is well documented that health care workers, especially those in areas with seriously ill patients, often do not follow recommended hand hygiene practices.

A typical alcohol-based hand rub contains between 60 percent and 95 percent ethanol with an emollient to prevent hand dryness and chapping. Alcohol at these concentrations effectively reduces hand levels of bacteria, including Mycobacterium tuberculosis and multidrug-resistant pathogens such as methicillin-resistant staph aureus (MRSA) and vancomycin-resistant enterococcus (VRE). Alcohol at these concentrations also denatures many viruses, including human immunodeficiency virus (HIV), influenza virus, respiratory syncytial virus, hepatitis B virus and hepatitis C virus. Hepatitis A virus may be inactivated by alcohol, but this depends on the alcohol concentration, length of time the hands are exposed to the alcohol and the variety of the particular virus. Alcohol is so effective in antisepsis that it is now an acceptable alternative to the scrubbing that surgical personnel have traditionally undergone before performing surgery.

Health care workers have had legitimate concerns about the effect of hand hygiene products on their skin. Dermatitis has been reported in health care workers who wash their hands frequently. Fortunately, alcohol-based products typically include emollients (softening and soothing agents) or humectants (moistening agents) or both. Use of hand lotions and creams can also decrease dryness and irritation. Allergic reactions have been reported very rarely as a result of exposure to an alcohol-based product; fortunately, the incidence seems to be much less than that seen with soaps.

The preferred agent to use for cleaning soiled hands is either plain (non-antimicrobial) soap and water or an antimicrobial soap and water. To use the soap properly, wet the hands first, apply the soap and rub the hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse the hands with water and dry them thoroughly with a disposable towel. Avoid reusable cloth towels. Use the towel to turn off the faucet. Hot water may increase the risk of dermatitis, so select a water temperature that is comfortable.

Non-antimicrobial soap works as a detergent, removing dirt, soil and various organic substances. Plain soap does not destroy microbes, but can remove many of them, especially when the provider washes for at least 30 seconds. Antimicrobial soaps can contain any of several different products, including chlorhexidine and iodophors. Different antiseptic agents show varying levels of effectiveness against different microbes. Chlorhexidine, for example, performs well against viruses and gram-negative and gram-positive bacteria, but not mycobacteria or fungi. Alcohols, on the other hand, perform better and faster than chlorhexidine, but their effects wear off sooner. There is no single agent that

is fast, effective against all microbes and persistent in its effects. The table summarizes the CDC's recommendations for good hand hygiene.

The EMS Agency's Role

For a hand hygiene program to work, the individual provider must have support from the EMS agency where he or she works. The organization needs to select an appropriate product or products, provide education and motivation, support the program administratively and monitor performance indicators. Selection of alcohol-based hand rubs and soaps should involve the people who will be using the products. Without acceptance by the end user, providers will not use hand rubs. Factors to consider include smell, consistency, color, efficacy, cost and means of dispensing.

A program of education and motivation should teach providers about the types of patient-care activities that can result in hand contamination and the advantages and disadvantages of various methods for cleaning hands. A number of factors can interfere with the success of such a program, so it must take into account: the belief that wearing gloves eliminates the need for hand hygiene; the lack of role models; provider skepticism toward the effectiveness of a hand-hygiene program; the traditional absence of hand-hygiene as an institutional priority; the lack of administrative sanctions for violators or rewards to those who comply and the lack of an institutional climate that supports safety.

An agency's administrative support of a hand hygiene program should include making improved hand hygiene an organizational priority, with the support and financial resources needed to support it. This includes making alcohol-based hand rubs easily available in numerous locations, e.g., on the wall in the ambulance patient compartment, in run kits, jump bags or other items frequently carried to patients and in providers' uniforms (pocket-sized containers are readily available). A hospital in Geneva, Switzerland, as part of its hand hygiene program, gave each employee a pocket-sized container of an alcohol-based hand rub. The institution's infection rate decreased steadily over time. Finally, an EMS agency should store supplies of alcohol-based hand rubs in cabinets or areas suitable for flammable materials. In Europe, where these products have been in use for some time, there have been rare reports of fires associated with alcohol-based hand rubs. Rubbing hands together until the alcohol is completely evaporated should prevent such incidents.

The effectiveness of a program of hand hygiene can be measured only if the organization evaluates its performance. This should take place through several different activities. The organization should periodically monitor frequency of compliance and keep records of those activities, measured as episodes of hand hygiene use/number of hand hygiene opportunities. HCWs should receive feedback on their performance. An indirect means of determining compliance is to monitor the volume of hand rub used. In hospitals, this amount is divided by the number of 1,000 patient-days. In EMS, a more appropriate denominator might be 100 or 1,000 patient transports. An easy item to monitor is compliance with policies regarding artificial nails.

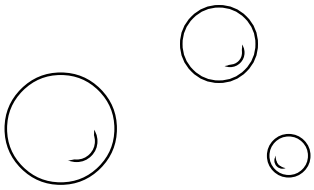
Resources

The CDC's report is available at *www.cdc.gov/handhygiene.* It has a wealth of easily accessible information on this often neglected topic. Other resources on hand hygiene CDC recommends include: *www.hopisafe.ch* (University of Geneva Hospitals, Geneva, Switzerland), *www.cdc.gov/ncidod/hip* (CDC, Atlanta, Georgia), *www.jr2.ox.ac.uk/bandolier/band88/b88-8.html* (Bandolier journal, United Kingdom) and *www.med.upenn.edu* (University of Pennsylvania, Philadelphia, Pennsylvania).

— Mike O'Keefe
State Training Coordinator

CDC Recommendations for Hand Hygiene

Some General Recommendations for Soiled or Unsoiled Hands:



- Wear gloves when contact with blood or other potentially infectious materials, mucous membranes, and nonintact skin could occur.
- Remove gloves after caring for a patient.
- Change gloves during patient care if moving from a contaminated body site to a clean body-site.
- Do not wear artificial nails or extenders when having direct contact with patients at high risk. Keep natural nail tips less than 1/4 inch long.

If your hands are **soiled,**
Before:
- eating

After:
- using a restroom
- suspected or proven exposure to Bacillus anthracis, the bacterium that causes anthrax (alcohols are ineffective against the spores):

- Wash with either a non-antimicrobial soap and water or an antimicrobial soap and water:
- Wet hands first, apply soap and rub hands together vigorously for at least 15 seconds, covering all surfaces of the hands and fingers. Rinse hands with water and dry thoroughly with a disposable towel. Use the towel to turn off the faucet. Avoid hot water because it may increase the risk of dermatitis.

If your hands are **unsoiled,**
Before:
- direct contact with patients
- inserting intravenous catheters
- eating

After:
- contact with a patient's intact skin (e.g., taking a pulse, checking a blood pressure or lifting a patient)
- contact with body fluids, excretions, mucous membranes, nonintact skin and wound dressings
- moving from a contaminated body site to a clean body-site
- contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient
- removing gloves

- Use an alcohol-based hand rub.
- Apply the amount of the product the manufacturer recommends to the palm of one hand and rub hands together, covering all surfaces of hands and fingers, until hands are dry.

Training UPDATE

EMS Instructor Course

The most recent EMS Instructor Course began in January at the University of Vermont in Burlington. In the fall, district chairs and trainers received applications with information on dates and fees and were asked to recommend EMT candidates. Preference was given to applicants who have demonstrated an interest in and commitment to teaching.

The purpose of the EMS instructor course is to prepare EMTs to coordinate courses at the EMT-B level and above. It is not intended to be a means of preparing training officers. The investment of time and energy a candidate must devote to the course is significant, so it is generally not the most prudent use of resources for a district to recommend someone for the course who plans to teach only at the first responder level.

EMT-Intermediate Curriculum

Now that the EMS Rules have completed their journey through the Administrative Procedures Act, our attention turns once again to the EMT-Intermediate curriculum changes. The plan for revising and implementing this major revision includes a number of steps.

The EMS Office is continuing the development of curriculum content and materials. This will also include revising the statewide protocols to reflect the new EMT-I scope of practice.

Later this year, pilot transition courses will begin. The first one or two courses will be conducted by the EMS Office and will be open to instructor-coordinators (ICs) who are EMT-Intermediates. Paramedics and registered nurses who are ICs will teach the course in conjunction with EMS Office staff. All involved will have the opportunity to evaluate and participate in revising the course. There will also be work sessions to develop written test questions, practical scoring criteria and instructional aids.

ICs who have completed the transition course will then be able to conduct transition courses on their own, developing a cadre of skill instructors and evaluators who will be able to assist with future courses. Many districts will probably update most of their existing EMT-Is before putting on the revised initial course.

The process of updating current providers is expected to take at least several years. There is no cutoff date beyond which all EMT-I courses will need to use the 2002 curriculum or recertifying EMT-Is will need to have completed a transition course.

Year in Review

The state's fiscal year ended June 30, providing us with an opportunity to look at what happened in training and education during fiscal year 2002.

Continuing Education

Once again, about 700 people attended the Vermont EMS conference last spring. The fourteenth annual conference saw the return of several popular speakers from past conferences, as well as some new faces. The popularity of pre-conference workshops continued to grow, with some sessions unable to accept all of the people who wished to attend. EMS Office staff also provided initial and continuing education by opening a number of EMT-Basic and EMT-Intermediate courses and making other presentations to EMS providers.

Courses

The number of EMT-Basic courses decreased slightly from last year, but the number of EMT students and graduating EMTs remained steady. In fiscal year 2001, approximately 261 of 313 (83.4%) students passed the EMT-B course. This past year, 262 of 316 (82.9%) students passed the EMT-B course. The number of EMT-Intermediate courses remained stable. EMT-B refresher courses continued to increase in popularity.

	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
EMT-Basic	14	16	17	10	16	17	21	25	19	14
EMT-Intermediate	11	12	11	14	7	10	11	8	10	10
EMT-Basic Refresher	NA	NA	NA	NA	NA	NA	2	11	13	19

Instructor Development

Twelve more EMTs graduated from the EMS Instructor course in March 2002. They all received orientation to Vermont's rules and policies at the end of the course. In all, 98 EMTs from Vermont have completed the course since it was first offered more than ten years ago. Most graduates are coordinating courses, but a significant number have never coordinated a course.

Certification Examinations

An EMT who was due to take the EMT-B recertification test received a reminder and an exam registration form in the mail. With the cooperation of district officials, course instructors and EMTs, the number of times EMS office staff traveled to conduct EMT certification exams remained constant and manageable.

Esophageal Tracheal Combitube

Sixteen more Combitube courses took place in the state. Twelve of the state's 13 EMS Districts had Combitube coverage from at least some of their EMT-Intermediates. An additional 233 providers took the course, bringing the total to 425.

National Standard EMT-Intermediate Curriculum Revised

Work continued on revising the National Highway Traffic Safety Administration's (NHTSA) National Standard EMT-Intermediate Curriculum. EMS Rule changes were drafted that, after approval through the Administrative Procedures Act, will expand the EMT-I scope of practice to include the Esophageal Tracheal Combitube, sublingual nitroglycerin, oral aspirin, intramuscular glucagon, intramuscular thiamine, nebulized beta agonist administration and use of a blood glucose meter, pulse oximeter and pediatric length-based resuscitation tape.

— Mike O'Keefe
State Training Coordinator

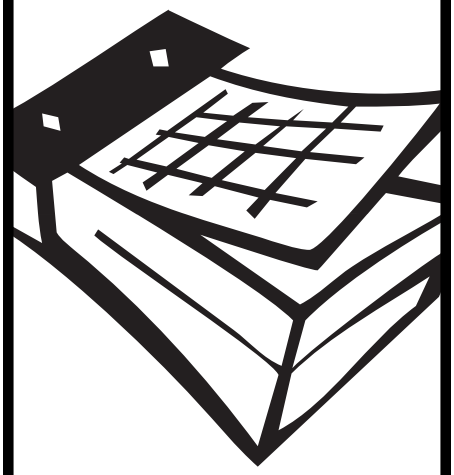
Year	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Exam Trips	60	28	24	29	29	33	31	42	35	44	46

Number of people holding Vermont EMS certification as of

	9/30/02	12/31/02
ECA	730	678
EMT–Basic (does not include advanced levels)	1251	1227
EMT–I	794	835
EMT–P	105	108
Total EMTs at all levels:	**2,150**	**2,170**

MARK YOUR CALENDAR!

2003 EMS **Conference** April 5 & 6



15th Annual Vermont EMS Conference
Awards Information

AS EMS CONFERENCE 2003 APPROACHES it is time again to consider nominating individuals or services for the 15th Annual EMS Awards. Since our first conference in 1989, over 110 of Vermont's EMS providers have been recognized for their outstanding contributions to EMS. Enclosed in this newsletter is a helpful form to assist those wishing to submit nominations. Please feel free to copy this form as necessary. Additional forms and criteria will soon be available at our website: *http://www.state.vt.us/health/ems*

When writing a nomination letter please keep in mind that a single high quality nomination letter is of greater significance than several poorly-crafted ones. Letters or narratives should be easy to comprehend and thorough in describing the accomplishments of a nominee. Below are a few helpful hints to consider when submitting a nomination:

- ❑ Consider the correct awards criteria for the individual you are interested in nominating.
- ❑ Remember, awards are based on an individual or service's overall contribution to the field of EMS. Avoid focusing on single acts of heroism.
- ❑ Be sure to completely identify the individual or service at some point in the nomination and the exact award you wish them to be considered for. Be sure that your nominee fits the criteria for the appropriate award category.
- ❑ Make a simple outline of your thoughts. Jumbled information is confusing and often clouds the characterizations that recognize outstanding nominees.
- ❑ When you write your nomination, keep in mind that it will be read by several committee members who may have little familiarity with the person or service.
- ❑ Have another person proofread your work.
- ❑ Please arrange for the nominee or service to be present at the Vermont EMS Awards Ceremony held Saturday, April 5, 2003.

EMS AWARDS CRITERIA

The annual Vermont EMS Awards Ceremony is a public opportunity to recognize our state's finest EMS professionals. In many ways these are the "people's choice" awards. Nominations come from colleagues, friends, other public safety agencies, municipal officials and grateful patients. The selection of the 2003 award recipients is conducted by committees of peers, including 2002 award winners. Nominations for this year's 2003 awards program must be postmarked no later than Friday, March 14th, 2003.

FIRST RESPONDER/EMERGENCY CARE ATTENDANT OF THE YEAR
EMT-BASIC OF THE YEAR
EMT-INTERMEDIATE OF THE YEAR
EMT-PARAMEDIC OF THE YEAR

- Is currently certified as a Vermont ECA, EMT-Basic, EMT-Intermediate, or EMT-Paramedic.
- Has made exceptional contributions to his/her EMS organization.
- Has strong and consistent clinical skills at his/her certification level.
- Has made an outstanding contribution to the EMS system either within or outside of his/her squad or service.

EMS EDUCATOR OF THE YEAR

- Has made a recognized contribution to the Vermont EMS system through outstanding organization or delivery of education to EMS providers.

EMS LEADER OF THE YEAR

- Is a leader of either a Vermont-licensed ambulance service, first responder service, EMS district, hospital, or the community.
- Has played a major role in EMS system development or the development of an individual EMS organization.
- Has demonstrated substantial leadership.
- Has represented the EMS system in a positive manner to other groups and organizations.

EMERGENCY NURSE OF THE YEAR
EMERGENCY PHYSICIAN OF THE YEAR

- Is currently a licensed nurse (at any level) or licensed physician.
- Has made an exceptional contribution to the Vermont EMS system.

FIRST RESPONDER SERVICE OF THE YEAR
AMBULANCE SERVICE OF THE YEAR

- Is currently a Vermont-licensed first response or ambulance service based in Vermont (licensure level is not to be considered).
- The service has made an outstanding contribution in the past year to public education.
- The service maintains positive, outstanding relations with the communities it serves and the local EMS District Board.
- The service takes meaningful and visible steps to assure the professionalism of personnel and the quality of patient care.
- The service has identified areas in which performance could be improved, and has taken organized steps to improve those areas in the past 2-3 years. (Examples may include response times, QA/QI programs, and/or advanced levels of training.)

VERMONT SAFE KIDS INJURY PREVENTION AWARD

- Is currently affiliated with an EMS district or a licensed ambulance or first responder service in Vermont.
- Has made an exceptional contribution to his/her organization and community in promoting injury prevention and public education.

VERMONT AMBULANCE ASSOCIATION CHUCK HOAG MEMORIAL SCHOLARSHIP

The Vermont Ambulance Association is pleased to offer the Chuck Hoag Memorial Scholarship in the amount of $500, available to any member in good standing of a Vermont-licensed EMS organization. This scholarship is to be used to further education in the provision or management of medical care. Recipients will be chosen by the VAA. Please submit nominations or applications to the Vermont EMS Office. These forms will then be forwarded to the VAA Scholarship Committee.

If you have any questions regarding this process or would like assistance in nominating an individual or service, please contact the Vermont EMS Office. It is a rare occasion that we take the time to recognize the many accomplishments in EMS. This is the ideal opportunity to recognize those who make a substantial contribution to EMS in our state!

— Steve Salengo
State EMS Operations Coordinator

2003 VERMONT EMS CONFERENCE

Award Nomination Guidance Form

Name of Nominee: _____

AWARD CATEGORY (check one):

- ❑ First Responder of the Year
- ❑ EMT-Basic of the Year
- ❑ EMT-Intermediate of the Year
- ❑ EMT-Paramedic of the Year
- ❑ EMS Leader of the Year
- ❑ EMS Educator of the Year
- ❑ EMS Nurse of the Year
- ❑ EMS Physician of the Year
- ❑ First Response Service of the Year
- ❑ Ambulance Service of the Year
- ❑ Vermont SAFE Kids Injury Prevention Award
- ❑ Vermont Ambulance Association Chuck Hoag Memorial Scholarship

Please attach narrative or letter of nomination to this form.

Some helpful hints to consider when submitting a nomination:

- Remember, awards are based on an individual or service's overall contribution to the field of EMS. Avoid focusing on single acts of heroism.
- Make a simple outline of your thoughts. Jumbled information is confusing and often clouds the characterizations that recognize outstanding nominees.
- When you write your nomination, keep in mind that it will be read by several committee members who may have little familiarity with the person or service.
- Be sure that your nominee fits the criteria for the appropriate award category.
- Have another person proofread your work.
- **Please arrange for the nominee or service to be present at the Awards Banquet held Saturday, April 5, 2003.**

All 2003 award nomination letters must be postmarked by March 14th, 2003 and mailed to:

Vermont EMS Conference
2003 EMS Awards
PO Box 64755
S Burlington VT 05406

Thank you for your nomination!

File Update

Have you moved or changed your phone number or name since the last time you certified or recertified? Let us know so we can keep our records up-to-date.

Change of name and address form:

OLD INFORMATION:	NEW INFORMATION:
Name _____	Name _____
Address _____	Address _____
_____ Zip _____	_____ Zip _____
Phone _____	Phone _____

Certification number _____

Send to: Vermont Dept. of Health, Division of Health Protection
EMS & Injury Prevention
P.O. Box 70, 108 Cherry Street
Burlington, VT 05402

Vermont Emergency Medical Services
108 Cherry Street
P.O. Box 70
Burlington, VT
05402

802-863-7310
1-800-244-0911
(within Vermont)

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